STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445190	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/22/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HOUSE, THE	**250 BELLEBROOK RD BRISTOL, TN 37620**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. The findings include: Observation and interview with the Maintenance Director, on January 22, 2014 at 10:43 a.m. confirmed corridor doors to residents rooms 202 and 309 failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 22, 2014.	K 018	1. Corridor doors to residents' room 202 and 309 were adjusted to close to a positive latch. 2. All resident room corridor doors were checked to ensure that they closed properly to a positive latch. 3. A log will be kept to check all doors that have positive latches on a regular weekly basis and during all fire drills. Dept. Heads responsible for their halls will check resident room corridor doors as part of their daily inspections and report to Maintenance any issues to ensure they close to a positive latch. 4. Maintenance Director will present logs at the regular QIP/QA monthly meeting and the report will be presented to the quarterly QA meeting X2.	1/22/14 1/22/14 1/22/14 2/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 2/14/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barrier's one (1) hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on January 22, 2014 at 2:00 p.m. confirmed unsealed penetrations in the smoke barrier walls at the following locations: 1) Above the smoke doors by room 302 2) Above the ceiling tiles by the 400 hall smoke doors. 3) Above the ceiling tiles by the 400 hall mechanical room. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 22, 2014.	K 025	1. Penetrations in the smoke barrier walls above the smoke doors by room 302, above the ceiling tiles by the 400 hall smoke doors and above the ceiling tiles by the 400 hall mechanical room were all sealed. 2. All areas typically hidden from view have the potential to be affected as well as anywhere there has been a recent repair. All locked areas were checked for penetrations and inspection of all recently repaired areas including sprinkler heads were checked to ensure that any penetration that occurred were sealed.	1/31/14 1/31/14
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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K 029	Continued From page 2 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined hazardous area ' s one (1) hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on January 22, 2014 between 11:10 a.m. and 2:00 p.m. confirmed unsealed penetrations in the following locations: 1) Kitchen mechanical room in the corner and above the door 2) Front mechanical room where the HVAC exhaust duct penetrates the ceiling 3) The mechanical room behind the 200 hall soiled linen room. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 22, 2014.	K 029	3. An inspection will be made of any area of the building that requires a repair and documentation will be kept ensuring that no penetrations occurred without sealing. This documentation will be kept by the Maintenance director and signed off by same. 4. Reports will be made to the Safety committee at the regular monthly meeting ensuring compliance with this documentation. Presentation of report and minutes of Safety committee will be done at the regular quarterly QA meeting by the Maintenance director. 1. Penetrations in the kitchen mechanical room, front mechanical room and the mechanical room behind the 200 hall were all sealed. 2. All areas typically hidden from view have the potential to be affected as well as anywhere there has been a recent repair. All locked areas were	2/14/14 2/14/14 1/31/14 1/31/14
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.	K 050		

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K 050	Continued From page 3 Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined staff failed to follow their fire plan. The findings include: Observation during a fire drill on January 22, 2014 at 10:50 a.m. confirmed staff relocated 14 residents from the day room to the adjacent corridor. Review of the facility fire plan specified to "clear hallways." This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 22, 2014.	~~K 050~~ K050	checked for penetrations and inspection of all recently repaired areas including sprinkler heads were checked to ensure that any penetration that occurred were sealed. 3. An inspection will be made of any area of the building that requires a repair and documentation will be kept ensuring that no penetrations occurred without sealing. This documentation will be kept by the Maintenance director and signed off by same. 4. Reports will be made to the Safety committee at the regular monthly meeting ensuring compliance with this documentation. Presentation of report and minutes of Safety committee will be done at the regular quarterly QA meeting by the Maintenance director. 1. All residents that were found to be in an affected area during the fire drill were removed to a safe area to	2/14/14 2/14/14 1/22/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 050	Continued From page 3 Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined staff failed to follow their fire plan. The findings include: Observation during a fire drill on January 22, 2014 at 10:50 a.m. confirmed staff relocated 14 residents from the day room to the adjacent corridor. Review of the facility fire plan specified to "clear hallways." This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 22, 2014.	K 050	ensure that hallways remain clear. 2. All residents have the potential to be affected, and fire drills will be conducted until all employees are cognizant of the procedure. 3. In-service will be provided to all employees and return demonstration will be utilized in the form of fire drills until all employees are comfortable with the procedures involving evacuation of the day room in the affected area. All new employees will have Fire Safety policies and Procedures explained in their Orientation. 4. Documentation of in-service and fire drill results will be presented to the Safety Committee at the regular monthly meeting X3 or until fire drills are procedurally correct. Results will be presented by the Maintenance director at the quarterly QA meeting X2.	2/14/14 2/14/14 2/14/14

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